

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 11377FILED APP 23 1940  
Registration District No. 12Primary Registration District No. 5569

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Jasper  
(b) City or town Joplin - galena  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Joplin---New Addition - R. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 yrs (Specify whether years, months or days)  
In this community \_\_\_\_\_

8. (a) PRINT FULL NAME Viola May Goade  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. none

4. Sex Fem 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bob Goade 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 9, 1903  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
36 5 26 hr. min.

9. Birthplace Parsons Kansas  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housekeeper

## 11. Industry or business

12. Name William H Tipton  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Swirl  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bob Goade  
(b) Address Garthage Mo.  
17. (a) BURIAL (b) Date thereof 3-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation FAIRVIEW CEMETERY  
18. (a) Signature of funeral director HURLBUT UND. Co  
(b) Address 212 Joplin St. Joplin, Mo.  
19. (a) 3-6-40 (b) Ed E. Jarne  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Jasper  
(c) City or town Joplin -- New Addition - Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. 1 - (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th  
year 1940 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from March 3-40  
1940, to March 5-40, 1940  
that I last saw him alive on \_\_\_\_\_, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline the cause to which death should be charged statistically

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 377  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature L. E. Kenna (M. D. or other) \_\_\_\_\_  
Address 311 Union Bank Date signed \_\_\_\_\_

RECEIVED

District Health Officer No. 6

District File No. 440-1053

Date Filed APR 10 1940

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. 95-9

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.